3490602628
Born 1/13/1983

5/25/2006 12:24:04 PM reyes, jason
Male Race: Hispanic

BP: 134/76-16-62-99 PHS

SINUS TACHYCARDIA
REPOL ABNRM, PROBABLE ISCHEMIA, DIFFUSE LEADS
V-rate> 99
ST dep, T neg, ant/lat/inf

Rate	101
PR	148
QRSD	87
QT	344
QTc	446

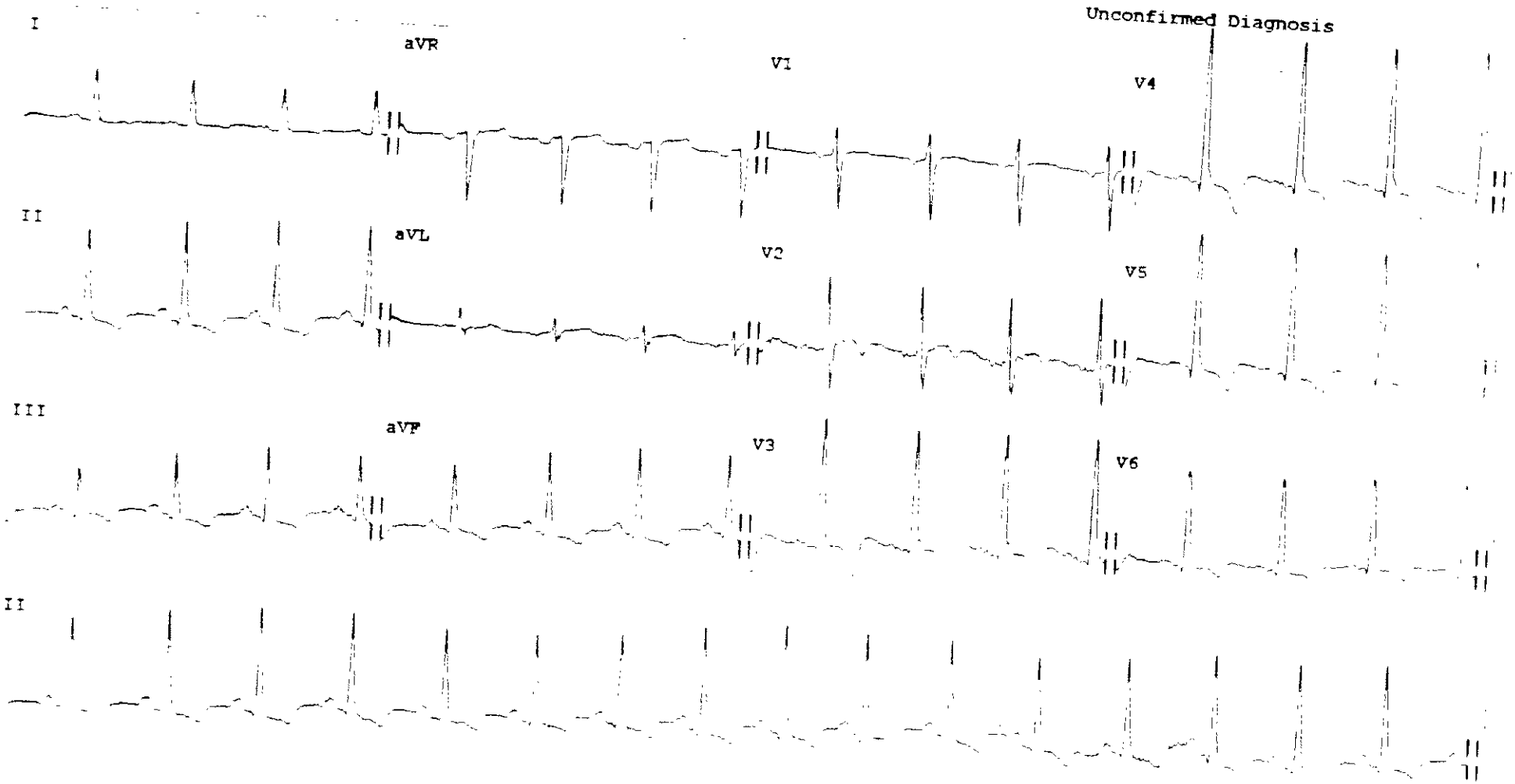
--AXIS--

P	75
QRS	60
T	263

- ABNORMAL ECG -

Fac: LOANER

Unconfirmed Diagnosis



Dev: 10009572 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV

NYC 0000090

60~ 0.15-150 Hz PH080A

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

ate _____ Physician _____

S 7014 (Rev. 7/04)

Reminder: Fully Complete the Problem List

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ / _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Thomas Schwaner PA

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

IS 5014 Rev. (4)

Reminder: Fully Complete the Problem List

Neuroscience Associates of New York

099 Targee Street, Staten Island, NY 10304 • 718/448-3210 • Fax 718/816-3579

Neurology
Stephen A. Kulick, M.D., F.A.A.N., F.A.C.P.
Steven B. Schwartzberg, M.D.
Audrey L. Halbern, M.D.

Pain Management
Germaine N. Rowe, M.D., F.A.A.P.M.R.
Glenn D. Babus, D.O.

Neurological Surgery
Edwin M. Chang, M.D., F.A.C.S.
John S. Shiau, M.D., F.A.C.S.
Anthony J.G. Alamia, M.D.

Emeritus
Harvey R. Leventhal, M.D., F.A.C.S.

Neuropsychology
Reuven L. Weiss, Ph.D.

May 1, 2006

Re: Jayson Reyes

To Whom It May Concern:

Mr. Reyes has been followed in our pain management practice since June 2003. He suffers from chronic left lower extremity pain secondary to RSD or reflex sympathetic dystrophy, which causes him to have a permanent disability. The patient has not been seen in our office in the last few months. Previously the patient had been managed on a regimen of medications including OxyContin 20 mg. q 6h.

If you have any further questions please feel free to contact our office at 718-448-3210 extension 2287.

Sincerely yours,

G. Rowe M.D. NA

Naomi Alcock, P.A.
Germaine N. Rowe, M.D.

NA/km
Voice ID: 16675441/Text ID: 13363965

HEALTHCARE ASSOCIATES in Medicine, PC
1099 Targee Street, Staten Island, NY 10304 • Phone: (718) 448-3210 • Fax: (718) 442-9085

FAX TRANSMISSION

DATE: 5/1/06

TO: Rosaria

COMPANY:

FAX: 398-8995

RE: Jayson Reyes

Number of pages including cover: 2

FROM: Naomi

DEPT: Pain Mgmt

FAX: 718-447-7192
TEL: 718-448-3210 X 2287

MESSAGE:

OFFICIAL NEW YORK STATE PRESCRIPTION

HEALTHCARE ASSOCIATES IN MEDICINE, P.C.

☐ GERMAINE N ROWE MD LIC. 204300
☐ GLENN D BABUS DO LIC. 228217
☐ NAOMI B ALCOCK PA LIC. 007057
☐ SABRINA R SIMONETTI PA LIC. 010118

1099 TARGEE STREET, STATEN ISLAND, NY 10304 (718) 448-3210

Patient Name Jayson Reyes Date 5/1/06

Address

City State Zip Age Sex M F

Rx PT 2-3x/wk x 6-8wks
+ ① lumbar epidural
Dx: Reflex sympathetic
Dystrophy/Causalgia
Bench PA

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED AS WRITTEN UNLESS PRESCRIBER WRITES "MEDICALLY NECESSARY"

REFILLS ☐ None ☐ As Directed

018DB1 12

PHARMACIST TEST AREA

This fax may co... you after the ap... recipient, you ar... information is to...

This fax may co... use of the perso... recipient, you ar... information is st... immediately.

...g sent to ... As the ...ner. This ...ited.

...ed for the ...ided ...g of this ...tify us

9920 4th Avenue, Brooklyn, NY 11209
3311 Hylan Boulevard, Staten Island, NY 10306
65 Columbus Avenue, Staten Island, NY 10304
1460 Victory Boulevard, Staten Island, NY 10301

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORI

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
INDICATION						

3

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
Reyes	Jason	349026228	NIC D7	Nkn

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
Daptomycin IV	8?	IV	QID	7D		
INDICATION						

2

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
3/12/06			Richard Dorf, RPA	0827	

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906 02628	A3 NIC	NKA

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
LIDOCAINE (MICR	IT	TOPICAL	QD	30d		
INDICATION						

1

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
3/11/06			Thomas Schwaner, PA	0715	Marie Colbert-Georges, MD

Write medication orders beginning from bottom of page

Chart Copy–White; Pharmacy Copy–Yellow

NYC 000006

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906021	628 NIC D3	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
3	OXYCONTIN	20mg	PO	BID	7d		
	INDICATION: PER BH PAIN MGT						
	CYMBALTA	60mg	PO	QD	7d		
	INDICATION: PER BH PAIN MGT						
	PROVIGIL	200mg	PO	Q AM	7d		
	INDICATION: PER BH PAIN MGT						
	DATE: 5/11/06 TIME:	PRESCRIBER SIGNATURE: [signature]	STAMP: 0564 Thomas Schwaner, PA				

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906021	628 NIC D3	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
2	TYLENOL	650mg	PO	BID	4d		
	INDICATION:						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	INDICATION:						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	INDICATION:						
	DATE: 5/9/06 TIME:	PRESCRIBER SIGNATURE: [signature]	STAMP: 0564 Harjinder Bhatti, MD Thomas Schwaner, PA				RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906021	628 NIC D3	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
1	OXYCONTIN	20mg	PO	BID	7d		
	INDICATION: PER BH PAIN MGT						
	CYMBALTA	60mg	PO	QD	7d		
	INDICATION:						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	PROVIGIL	200mg	PO	Q AM	7d		
	INDICATION: PER BH PAIN MGT						
	DATE: 5/5/06 TIME:	PRESCRIBER SIGNATURE: [signature]	STAMP: 0564 Harjinder Bhatti, MD Thomas Schwaner, PA				RPh

Write medication orders beginning from bottom of page.
Chart Copy–White; Pharmacy Copy–Yellow

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

PT

Patients' Name REYES, JASON DOB 1/13/82

FROM NIC 03 / 349060262B
Correctional institution Inmate no.

Referred to PT
Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

23 YO M HX OF
RSD REFLEX SYMPATHETIC DYSTRO
SINCE SEPT 2002
BILATERAL LEG PAIN + WEAKNESS
HYPERESTHESIA TO (L) HEEL

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request: PT FOR ROM TO
LOWER EXTREMITIES (AS TOLERATED)

Date 5/4/06 Referring Physician ~~Thomas Schwaner, PA~~ Phone Harjinder Bhatti, MD Approved

Consultation, findings and recommendations:

NYC 0000097

Pt has report of RSD, 2° to work related injury; 5/5 of RSB to ⓒ foot m/l and plantar surface c ↓ ROM @ ankle c/p evident; pt has hyperesthesia to DCA c cog'd oscillations evident when transferring w. Brig or walking. gait is impaired by RSD c ↑ (6/10) pain c/o ~~pain~~ brought on with w.b. ↓ to ↓ pain dysesthesia c physical agents (U.S. hot) return to P.T.

Date Physician

S 5014 (Rev. 5-94) Reminder: Fully Complete the Problem List

D 3

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME: Reyes, Jasm
ID #: 349-06-02628
DIAGNOSIS: Reflex Sympathetic Dyst
ALLERGY: Fentanyl LOC: D2A

PATIENT LAST NAME	FIRST NAME
Reyes	Jasm
ID# 349060262	LOCATION N.C D2A
DRUG Cymbalta	NEW
INDICATION	
DOSE 40 mg	ROUTE PO
FREQUENCY daily	DURATION 2 wks
DATE 4/19/06	TIME 6 PM
MD / PA SIGNATURE	Habib Kamkhaji, MD
D / C DATE	NURSE TIME RPH

PATIENT LAST NAME	FIRST NAME
Reyes	Jasm
ID # 349060262	LOCATION N2C Dorm 2
DRUG Oxycontin SR	NEW
INDICATION Pain Mgmt	
DOSE 20 mg	ROUTE PO
FREQUENCY q 12 Hours	DURATION 7 days
DATE 4/19/06	TIME 9p
MD / PA SIGNATURE	Rajeev L. Ahari, MD
D / C DATE	NURSE TIME 8pm RPH

Reyes	Jasm
ID # 349060262	LOCATION D2
DRUG Reglan	NEW
INDICATION	
DOSE 800 MG	ROUTE PO
FREQUENCY 1.0 AM + 1.0 PM	DURATION until
DATE 4/19	TIME
MD / PA SIGNATURE	M.D. 0770 SINAI
D / C DATE	NURSE TIME RPH

MONTH April YEAR 2006

D / HR	18	19	20	21	22	23	24	25	26	27	28	29	30
9A	NS	TE											
D / HR													

MONTH April YEAR 06

D / HR	4/19	4/20	21	22	23	24	25	26
9A	NS	TE	NS	NS	NS	(1)	X	
D / HR		TE	TE	TE	TE	NS	X	

MONTH YEAR

D / HR	
D / HR	

Drugs Not Administered Code Key:

1. Refusal
2. Out of Court
3. Out of Hospital/specialty clinic
4. Off Unit (i.e. visit, recreation, library)
5. Withheld (pending lab, abnormal lab, and/or vital signs)
6. Non-formulary and not available at time of administration
7. Not in cassette, pharmacy notified
8. Medication given to take to court or hospital specialty clinic
9. OOS (Out of Stock) at time of administration

CHS 1761 (Rev 6/04)

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME: Reyes, Jason
ID #: 349-06-02628
DIAGNOSIS: Reflex Sympathetic Dystr
ALLERGY: Fentanyl LOC: D 2A

PATIENT LAST NAME: Reyes | FIRST NAME: Jason
ID #: 349062628 | LOCATION: Nic D2A
DRUG: OXYcontin SR | NEW:
INDICATION: Pain
DOSE: 10 mg | ROUTE: PO | RENEW:
FREQUENCY: q12hrs | DURATION: 2 days then taper | CHANGE:
DATE: 4/18/06 | TIME: 6 PM
MD / PA SIGNATURE: Habib Kamkhaji, MD
D / C DATE: | NURSE: | TIME: 0730 | RPH:

MONTH APRIL YEAR 2006

D/HR	18	19
9A	∅	
9P	∅	

D/C 4/19/06

PATIENT LAST NAME: Reyes | FIRST NAME: Jason
ID #: 349062628 | LOCATION: Nic D2A
DRUG: Neurontin | NEW:
INDICATION:
DOSE: 300 mg | ROUTE: PO | RENEW:
FREQUENCY: TID | DURATION: 2 wks | CHANGE:
DATE: 4/18/06 | TIME: 6 PM
MD / PA SIGNATURE: Habib Kamkhaji, MD
D / C DATE: | NURSE: | TIME: | RPH:

MONTH APRIL YEAR 2006

D/HR	18	19	20	21	22	23	24	25	26	27	28	29	30	5/1
5A	X													
1P														
9P														

D/C 5/1

PATIENT LAST NAME: Reyes | FIRST NAME: Jason
ID #: 349062628 | LOCATION: Nic D2A
DRUG: Lidoderm Patch 5% | NEW:
INDICATION:
DOSE: 1 Patch | ROUTE: Topical | RENEW:
FREQUENCY: BID pm | DURATION: 2 wks | CHANGE:
DATE: 4/18/06 | TIME: Habib Kamkhaji, MD
MD / PA SIGNATURE:
D / C DATE: | NURSE: | TIME: 0730 | RPH:

MONTH APRIL / MAY YEAR 2006

D/HR	18	19	20	21	22	23	24	25	26	27	28	29	30	5/1
9A														
9P														

D/C 5/1

1. Refusal
2. Out of Court
3. Out of Hospital/specialty clinic
4. Off Unit (i.e. visit, recreation, library)
5. Withheld (pending lab, abnormal lab, and/or vital signs)
6. Non-formulary and not available at time of administration
7. Not in cassette, pharmacy notified
8. Medication given to take to court or hospital specialty clinic
9. OOS (Out of Stock) at time of administration

CHS 1061 (Rev. 6.04)

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME: Reyes Jason
ID #: 3490602628
DIAGNOSIS: Reflex sympathetic dystrophy
ALLERGY: Fentanyl LOC. O2A

PATIENT LAST NAME: Reyes | FIRST NAME: Jason
ID#: 3490602628 | LOCATION: NSC Dorm 2A
DRUG: Cymbalta | NEW:
INDICATION: RSD
DOSE: 60 mg | ROUTE: PO | RENEW:
FREQUENCY: QD | DURATION: 5 days | CHANGE:
DATE: 9/21/06 | TIME: 10 am
MD / PA SIGNATURE: Rajeev L. Achari, MD
D/C DATE: 4/26/06 | NURSE: Eujeli | TIME: 11 am

MONTH April YEAR 06

D/HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
9A	NS	NS	NS	①																											
D/HR																															

4/26 taken off DATE

PATIENT LAST NAME: Reyes | FIRST NAME: Jason
ID#: 3490602628 | LOCATION: NSC Dorm 2A
DRUG: Provigil | NEW:
INDICATION: RSD
DOSE: 200 mg | ROUTE: PO | RENEW:
FREQUENCY: 7 AM | DURATION: 5 days | CHANGE:
DATE: 9/21/06 | TIME: 10 am
MD / PA SIGNATURE: Rajeev L. Achari, MD
D/C DATE: 4/26/06 | NURSE: Eujeli | TIME: 11 am | RPH:

MONTH April YEAR 06

D/HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
9A	⑥	⑥	⑥	⑥																											
D/HR																															

OK 4/26/06 taken off DATE

MONTH YEAR

D/HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
D/HR																															

PROFILE BY: DATE: TIME:

Drugs Not Administered Code Key:

1. Refusal
2. Out of Court
3. Out of Hospital/specialty clinic
4. Off Unit (i.e. visit, recreation, library)
5. Withheld (pending lab, abnormal lab, and/or vital signs)
6. Non-formulary and not available at time of administration
7. Not in cassette, pharmacy notified
8. Medication given to take to court or hospital specialty clinic
9. OOS (Out of Stock) at time of administration

CHS 1361 (Rev 6/04)

STAT OR SINGLE DOSE MEDICATIONS

ORDER DATE	MEDICATION / DOSE ROUTE	DATE	TIME	INIT	REASON AND RESPONSE

MEDICATIONS NOT ADMINISTERED

ORDER DATE	MEDICATION / DOSE ROUTE	DATE	TIME	INIT	REASON AND INTERVENTION
4/24/08	Cymbalta 60mg, Avapro 300mg po	4/24/08	9am	[illegible]	No Show

NURSE'S SIGNATURE

DATE	FULL SIGNATURE	INITIALS	PRINT NAME
4/24/08	[illegible] Johnson	[illegible]	E. Johnson

S 1761 (Rev 6/04)

STAT OR SINGLE DOSE MEDICATIONS

ORDER DATE	MEDICATION	DOSE ROUTE	DATE	TIME	INIT	REASON AND RESPONSE

MEDICATIONS NOT ADMINISTERED

ORDER DATE	MEDICATION	DOSE ROUTE	DATE	TIME	INIT	REASON AND INTERVENTION
4/19/06	Inderal Pellet	by mouth	4/19/06	9AM	O	NOT Consult
4/18/06	Nitrostat 3 Dose	p.o	4/23/06	9a	[illegible]	No show
4/18/06	Inderal Pellet	by mouth	4/23/06	9a	[illegible]	No show

NURSE'S SIGNATURE

DATE	FULL SIGNATURE	INITIALS	PRINT NAME
4/18/06	L Richardson	LR	L RICHARDSON
4/19/06	[illegible]	O	Winsome Douglas-Hewitt, LPN
4/21	[illegible]	9W	
4/22	T Effeh	T.E	T. E JEH
4/23/06	[illegible]	[illegible]	E Johnson
4/25	[illegible]	[illegible]	[illegible]

STAT OR SINGLE DOSE MEDICATIONS

ORDER DATE	MEDICATION / DOSE ROUTE	DATE	TIME	INIT	REASON AND RESPONSE

MEDICATIONS NOT ADMINISTERED

ORDER DATE	MEDICATION / DOSE ROUTE	DATE	TIME	INIT	REASON AND INTERVENTION
4/20/06	Oxycontin 20mg PO	4/21/06	9am	[illegible]	NO [illegible]

NURSE'S SIGNATURE

DATE	FULL SIGNATURE	INITIALS	PRINT NAME
4/19/06	[illegible]	[illegible]	Winsome Douglas-Hewitt, LPN
4/21	T. E[illegible]		
4/21/06	[illegible]	T.E	T. E[illegible] H
4/25	[illegible]	[illegible]	for Tolmos
			MONTH CARE

S 3061 (Rev. 1/04)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM B

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349 06 02628	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	NEURONTIN	800 mg	PO	TID	14d		
3	INDICATION						
	COLACE	200 mg	PO	QD	30d		
	INDICATION						
	LIDOCAINE (MTCH)	PT	~~PO~~ TOPICAL	QD	14d		
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPH
5/2/06			Harjinder Bhatti, MD Thomas Schwaner, PA 0864	

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349 06 02628	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	OXYCONTIN SR	20 mg	PO	BID	7d		
2	INDICATION						
	CEMBALTA	60 mg	PO	QD	7d		
	INDICATION						
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPH
5/2/06			Harjinder Bhatti, MD Thomas Schwaner, PA 0864	

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349 06 02628	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	OXYCONTIN SR	20 mg	PO	BID	7d		
1	INDICATION PER PAIN MGMT ARCUEUIL						
	CEMBALTA	60 mg	PO	QD	7d		
	INDICATION PER PAIN MGMT						
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION PER PAIN MGMT						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPH
4/27	06		Harjinder Bhatti, MD Thomas Schwaner, PA 0864	

Write medication orders beginning from bottom of page

Chart Copy–White; Pharmacy Copy–Yellow

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262S	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
3	HC 1% CREAM	PF	TOPICAL NARES	BID	14d		
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DATE 4/26 TIME 06	PRESCRIBER SIGNATURE [signature] PA	STAMP Harjinder Bhatti, MD Thomas Schwaner, PA				RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262S	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
2	NEURONTIN	300mg	PO	TID	14d		
	INDICATION	PER PAIN MGN (RELEASE)					
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DATE 4/26 TIME 06	PRESCRIBER SIGNATURE [signature] Thomas Schwaner PA	STAMP Harjinder Bhatti, MD Thomas Schwaner, PA				RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262S	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
1	OXYCONTIN SR	20mg	PO	BID	7d		
	INDICATION	PER PAIN MGN (RELEASE)					
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	CYMBALTA	60mg	PO	QD	7d		
	INDICATION	PER PAIN MGN (RELEASE)					
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	PROVIGIL	200mg	PO	QAM	7d		
	INDICATION	PER PAIN MGN (RELEASE)					
	DATE 4/26 TIME 06	PRESCRIBER SIGNATURE [signature] Thomas Schwaner PA Harjinder Bhatti, MD					

Write medication orders beginning from bottom of page

Chart Copy-White, Pharmacy Copy-Yellow

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

CHS FORM A

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

ALLERGIES _____

4

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME / RPH

1

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME / RPH

5

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME / RPH

2

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME / RPH

6

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME / RPH

3

PATIENT LAST NAME	FIRST NAME	
ID #	LOCATION	
DRUG		NEW
INDICATION		
DOSE	ROUTE	RENEW
FREQUENCY	DURATION	CHANGE
DATE	TIME	
MD / PA SIGNATURE		
D / C DATE	NURSE	TIME

NYC 000106

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

CHS FORM A

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

ALLERGIES _____

4

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

1

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

5

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

2

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

6

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

3

PATIENT LAST NAME	FIRST NAME
ID #	LOCATION
DRUG	NEW
INDICATION	
DOSE / ROUTE	RENEW
FREQUENCY / DURATION	CHANGE
DATE / TIME	
MD / PA SIGNATURE	
D / C DATE / NURSE / TIME	RPH

NYC 000107

CHS 312 (Rev 4/04) NURSE COPY WHITE

4/18/06

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ / _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

ate _____ Physician _____

NYC 000108

Reminder: Fully Complete the Problem List

NYC HEALTH AND HOSPITAL CORPORATION
CORRECTIONAL HEALTH SERVICES

DOCTORS ORDERS LIST

Reyes Jason
349060262 8
1/13/83

NAME _____ ROOM NO. _____

DATE	BY WHOM	ORDERED	BOOK & CASE # _____ NYSIS # _____ D.O.B. _____ ADMISSION TO CDU: _____ SPRUNG # _____ CELL # _____	DATE	BY WHOM
				DISCONTINUED	
1/18/06	KO		DIAGNOSIS: Reflex sympathetic dystrophy		
N.C.			CONDITION: satisfactory		
Dc			VITAL SIGNS: Q shift		
			ACTIVITY: as tolerated		
			ALLERGY: Fentanyl		
			RESPIRATORY ISOLATION:		
			DIET: Regular		
			LABORATORY/DIAGNOSTIC TESTS: (PLEASE CHECK (✓)		
			_____CBC WITH DIFFERENTIAL		
			_____RPR / MHA – TP		
			_____SMA – 20		
			_____URINALYSIS		
			_____CHEST X-RAY: PA AND LATERAL VIEWS		
			ADDITIONAL TESTS: CHECK ONLY IF INDICATED:		
			_____PREGNANCY TEST (URINE)		
			_____HEPATITIS REFLEX PANEL		
			_____ESR		
			_____LYMPHOCYTE EVALUATION (T-CELLS PROFILE)		
			_____G – 6 – PD		
			_____SPUTUM GRAM STAIN AND C/S		
			_____12 – LEAD ELECTROCARDIOGRAM (EKG)		
			_____OTHERS: PLEASE SPECIFY		
			SPUTUM INDUCTION FOR AFB SMEARS, CULTURE AND		
			SENSITIVITY ONCE A DAY FOR 3 DAYS		
			TEST FOR VISUAL ACUITY WITH SNELLEN'S CHART		
			TEST FOR COLOR VISION WITH ISHIHARA PLATES		

NYC 000109

Form MM009/Front

DATE	BY WHOM		DATE	BY WHOM
ORDERED			DISCONTINUED	
		REFERRALS: CHECK ONLY IF INDICATED.		
		____ HIV TESTING / COUNSELLING		
		____ MENTAL HEALTH		
		____ KEEP COUNSELOR		
		____ DIETARY SERVICE		
		____ SOCIAL SERVICE		
		____ DISCHARGE PLANNING		
		MEDICATIONS: PATIENT'S WEIGHT ____ (LBS.) ____ (KG.)		
		____ INH 300 MG P.O. O.D. X 14 DAYS		
		____ PYRIDOXINE (VIT. B6) 50 MG P.O. O.D. X 14 DAYS		
		____ RIFAMPIN 600 MG P.O. O.D. X 14 DAYS		
		____ ETHAMBUTOL (25 MG / KG / DAY FOR THE		
		1ST MONTH, THEN 15 MG / KG / DAY THERAFTER		
		____ MG P.O. X 14 DAYS		
		____ PZA (25 – 35 MG / KG / DAY)		
		____ MG. P.O. O.D. X 14 DAYS		
		OTHERS:		

Habib Kamkhaji, MD

M.D.

PRINT NAME

SIGNATURE

NYC 000116

Form VM009/Back

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DOCTORS ORDERS

Name Reyes Jason Case No. 349-06-026-

Ward

DATE ORDERED	BY WHOM		DATE DISCONTINUED	BY WHOM
4/19/06	12-8 AM			
4/20/06	12-8			
4/21/06	12-8 AM			
4/22/06	12-5			
4/23/06	12-8			
4/24/06	12-8			

MS 141 (Rev. 7-04)

Attn: NIC

118 Sixth Ave

Dept Dorm 2-A

Dr Warden

Re: Jason Reyes

349060628

Medical Info:

Neuroscience Associates of New York

999 Forgan Street Staten Island, NY 10304 • 718/448-3210 • Fax 718/815-1390

Neurology
Stephen A Kirch M.D. F.A.A.N. F.A.C.P.
Neelam Sethi Chhabra M.D.
Audrey L. Shoshan M.D.
Pain Management
Germaine N. Rowe, M.D., F.A.A.P.M.R.
Glenn D. Bogue D.O.

Neurological Surgery
Kevin M. Chang, M.D. - F.A.C.S.
John S. Shiau, M.D. F.A.C.S.
Anthony J.G. Acerra, M.D.
Emeritus
Harvey R. Greenfield M.D. F.A.C.S.
Neuropsychology
Deborah L. Wade, Ph.D.

March 20, 2006

Re Jayson Reyes

To Whom It May Concern:

Mr. Reyes has been a patient in our pain management practice since June of 2003. He is being treated medically for RSD or reflex sympathetic dystrophy also known as complex regional pain syndrome. RSD is a chronic neurological disease caused by a disturbance in the sympathetic nervous system. RSD is characterized by symptoms of severe pain and increased sensitivity in the area of pain associated also with swelling, color and temperature changes, circulatory changes as well as impairment in motor function or reduced range of motion.

For the patient's pain symptoms, he has been previously treated with a regimen of Oxycontin, 30 milligrams, every 12 hours; Cymbalta, 60 milligrams a day; and Lidoderm patches, 12 hours on and 12 hours off as well as Provigil, 200 milligrams a day.

If you have any further questions, please feel free to contact us in our office at 718 448-3210 ext. 2287.

Sincerely yours,

Naomi Alcock, P.A.
Germaine N. Rowe, M.D.

NA:tw
Order ID: [illegible] ID: [illegible]

HEALTHCARE ASSOCIATES in Medicine, P.C.
[illegible] Forest Street, Staten Island, NY 10[illegible] • Phone: (718) 448-3210 • Fax: (718) 442-9085

FAX TRANSMISSION

DATE 2/13/06

TO Rosario 398-8995 FROM Jerome

COMPANY:

FAX

RE:

Number of p

MESSAGE

Neuroscience Associates of New York
A Division of HEALTHCARE ASSOCIATES in Medicine, P.C.
1099 Forest Street, Staten Island, N.Y. 10304 • 718/448-3210
9420 4th Avenue, Brooklyn, N.Y. 11209 • 718/238-0878

Neurology
Herbert A. Lurie, M.D. FAAN FACP
Steven B. Schwartzberg, M.D.
Audrey E. Nielsen, M.D.
Pain Management
Bernard N. Sang, M.D. FAAPM&R
Sandra Reed, DO

Neurological Surgery
Edwin M. Ohnstad, M.D. F.A.C.S.
John S. Shaw, M.D., F.A.C.S.
Anthony J. B. Adams, M.D.

Emeritus
Harold B. Lowenthal, M.D. F.A.C.S.

Date 2/13/06

Re: Reyes, Jayson

To Whom It May Concern:

Please be advised that the above named patient is under my care for Chronic Foot pain 2° reflex sympathetic dystrophy (RSD).

At the present time the patient:

___ may return to work full duty

___ may return to work with the following limitations:

___ May not return to work

___ is unable to drive a car.

Pt is treated medically for his pain symptoms with a regimen of Oxycontin 20 mg every 12 hrs, Oxycodone 10 mg/day, and Lidoderm patches 12 hrs on, 12 hrs off. He also uses Percocet 300 mg/day. If you have any further questions, pls contact this office.

Sincerely, MD Reed DO

This fax may c
you after the
recipient, you
information is

This fax may c
use of the per
recipient, you
information is
immediately

444 Avenue

NIC D2A

TEMPORARY PERMIT FOR CANES/MEDICAL ITEMS

TO EMTC- DEPARTMENT OF CORRECTIONS
OFFICER IN CHARGE OF HOUSING AREA—

DATE ISSUED 4/13/06

DATE EXPIRED INDEFINITE

INMATE REYES, JASON (NAME) 3406D2628 (BOOK-N-CASE NUMBER)
DUE TO MEDICAL REASONS HAS BEEN AUTHORIZED THE USE OF CRUTCHES
BY RECOMMENDATION OF THE MEDICAL DEPARTMENT.

SIGNATURE OF MEDICAL STAFF OF EMTC

New York City Health and Hospitals Corporation

INTER-HOSPITAL TRANSFER RECORD

From (Sending Hospital): Bellevue

To (Receiving Hospital): Rikers NIC - Dorm 2B

Date: 4/17/06

Clinical Service: Medicine

Patient's Name (Last)	(First)	Sex	Age	Birthdate	Medical Record #
Reyes	Jayson	M	23	1/13/83	3086604

Address	Borough	Zip	Apt. #	Telephone #

Next of Kin (Name)	Relationship	Telephone #	Transfer Notification
			☐ YES ☐ NO

Name/Title of Person Contacted at Receiving Hospital: DR. Ihim / Dr Bashir — Telephone #:

Diagnosis and Remarks: Reflex sympathetic dystrophy

Past Medical History (including allergies, medications taken): RSD 2/2 ankle trauma

Physical Findings and Treatment (including medications, IV fluids, and blood administered, lab and X-ray results, procedures done)

Oxycontin SR 10 mg q12 (titrate up PRN) Cymbalta 40 mg QD
Neurontin 300 PO QID Provigil 200 mg q AM
Lidoderm patch (or ointment) Pt would benefit from wheelchair

Special Equipment Transferred:
☐ X-Rays to Accompany Patient ☐ Laboratory Reports Attached ☐ Copy of E.R. Chart

Reason for Transfer:
☐ HHC Bed Unavailable ☐ Services Not Available ☐ Patient Request ☐ Other:

Patient's Condition at Transfer: ☐ Critical ☐ Serious ☐ Fair ☐ Good

Approved — Physician in Charge (Sending Hospital)
Name Print: Scott SCHWARZ Title: PGY 2
Signature: MD Telephone #: 917-401-1403

Approved — Hospital Administrator
Name Print:
Signature: Time:

Emergency Medical Service Notified Time: AM/PM
Time Ambulance Arrived at E.R. AM/PM
Operator:
Time Patient Transferred AM/PM

Receiving Physician
Name Print: MD
Signature: MD Time:

Name of Accompanying Staff Member in Ambulance
☐ MD ☐ RN

Patients Valuables:
☐ Sent with Patient ☐ Given to Family ☐ Retained at Hospital
Staff Signature:

Patient's Clothing:
☐ Destroyed ☐ Discarded ☐ Given to Family ☐ Retained at Hospital
Family Signature:
Family Signature:

General Comments/Mental Status Evaluation:

NYC 000116

HHC 669 (July 83)

Distribution: White – Patient Copy Canary – Hospital Copy

CONSULTATION REQUEST

.W YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ / _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

ıte _____ Physician _____

Reminder: Fully Complete the Problem List

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
ND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ / _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

te _____ Physician _____

5014 (Rev. 1-04)

Reminder: Fully Complete the Problem List

Printed: Apr 17, 2006 01:15 pm
Bellevue Hospital Center
462 First Avenue
New York, NY 10016

Reyes,Jayson 3086604-2 EP?I
19S S46SA1 Age:23Y Sex:male
DOB: Jan 13, 1983 MR# 3086604
Admitted: Apr 15, 2006
Attndg Physician: Bails,Douglas,MD
Service: General Medicine

Apr 17, 2006 01:14 pm: Discharge Summary

Disch Date : Mon, 17 Apr 2006
Reason for Admission : Left foot pain
Findings/Course :

Pt is a 23 yo DOC prisoner with h/o reflex sympathetic dystrophy secondary to forklift vs left ankle resulting in severe sprain at Home Depot who presents with inability to walk and worsening left ankle pain ever since being arrested when his outpatient pain regimen was discontinued. He had previously been on Oxycontin SR 20 q12, Cymbalta 60 qd, Lidoderm patch, Provigil 200 mg qd. All of these meds were discontinued when pt was arrested. Pt was evaluated by Neurology in ER who recommended Percocet, Neurontin and Lidocaine ointment.

Pt reported some improvement in his pain symptoms. Ankle film was negative. He was not able to ambulated however.

Pt stable for discharge. Should receive Oxycontin SR 10 q12 and titrate up PRN, Neurontin 300 TID, Lidoderm patch or ointment if patch not available. Would consider adding Cymbalta and or Provigil if symptoms continue. Would also recommend pt receiving a wheelchair.

Disch Prescriptions : Oxycontin SR 10 q12, Neurontin 300 tid, Lidoderm patch
Disposition : transferred to RIKERS
Problem # 1 : Reflex Sympathetic Dystrophy, Lower Limbs

Electronically signed by Schwarz,Scott, MD
Apr 17, 2006

NYC 000119

Bellevue Hospital Center
Discharge Instruction Sheet

IMPORTANT: Please bring this form to your first appointment with your doctor.

IMPORTANTE: Por favor, traiga ésta documento a la primera visita con su médico.

重要通知: 第一次看醫生時請您帶上這張表格。

[illegible] 04/15/

MD to Complete

Diagnoses: Left Sympathetic Dystrophy

Surgery/Special Procedures:

Home Care Ordered: ☐ Not Required ☐ Yes Give DVT Discharge Instructions ☐

Activity Limitations: ☐ None ☒ Yes/Specify: As tolerated

Allergies: ☐ No Known Allergy ☒ Yes/Specify: [illegible] | Diet Ordered: ☒ Regular ☐ Other/Specify:

Your Medications Are: ☐ **No Medication Ordered**

Name	Dose	How Often	Reason for Taking
[illegible]			

Additional Instructions (e.g., labs, tests, non-drug pain management, etc.):

Your Follow-up Care: ☐ To Be Seen in Bellevue Clinic: see below

☐ Referred to Bellevue Stop Smoking Program at 5 South 51, (212) 562-4748.

MD Requested Appointment			SMS Appt Given	
Clinic	Date Requested	MD (if known) PRINT	Date	Time
[illegible] (X) NEW ( ) REV	____ days or ____ weeks	Dr [illegible]		
( ) NEW ( ) REV	____ days or ____ weeks			
( ) NEW ( ) REV	____ days or ____ weeks			

☐ Patient Requests Appointment with Private MD.

☐ Refer to Non-Bellevue Managed Care Provider.

MD Name (**Print**): MD Signature: ID Number:

Date:

Hospital Transfer Form

Please use ball point pen and print legibly.

Referring DOC Facility: _____

Name of referring MD _____
(Please Print)

Hospital Run: ❑ EMS ❑ DOC: 3.3 hr. MD Phone # _____

Date: _____ Time: _____ AM/PM

Referred to: ❑ KCHC ❑ Elmhurst ❑ Bellevue

❑ Other: _____

Patient Name: _____

B&C #: _____ DOB: _____
(Please Print)

Contact Urgicare if you have questions: **Beeper# 917-949-1234**
Phone# 718-546-4333

COMPLAINT:

PE

PMH:

Studies/Labs

MEDS

Tx @ RI

Allergies:

Significant ED findings/studies:

Discharge Dx:

Recommended FU:

Fax completed form to Urgicare Center @ time of discharge - 718-546-4382

Physician Name **(print)** _____ Signature: _____ Date: _____
Phone # _____

CONTACT URGICARE IF YOU HAVE QUESTIONS / INFORMATION.

FOR BOROUGH HOUSES CONTACT REFERRING PRACTITIONER (ABOVE).

BEEPER #: 917-949-1234
PHONE #: 718-546-4333

HEALTHCARE ASSOCIATES in Medicine, PC

1099 Targee Street, Staten Island, NY 10304 • Phone (718) 448-3210 • Fax (718) 442-8045

FAX TRANSMISSION

DATE 4/1/06

TO Rebecca

FROM: Dawn

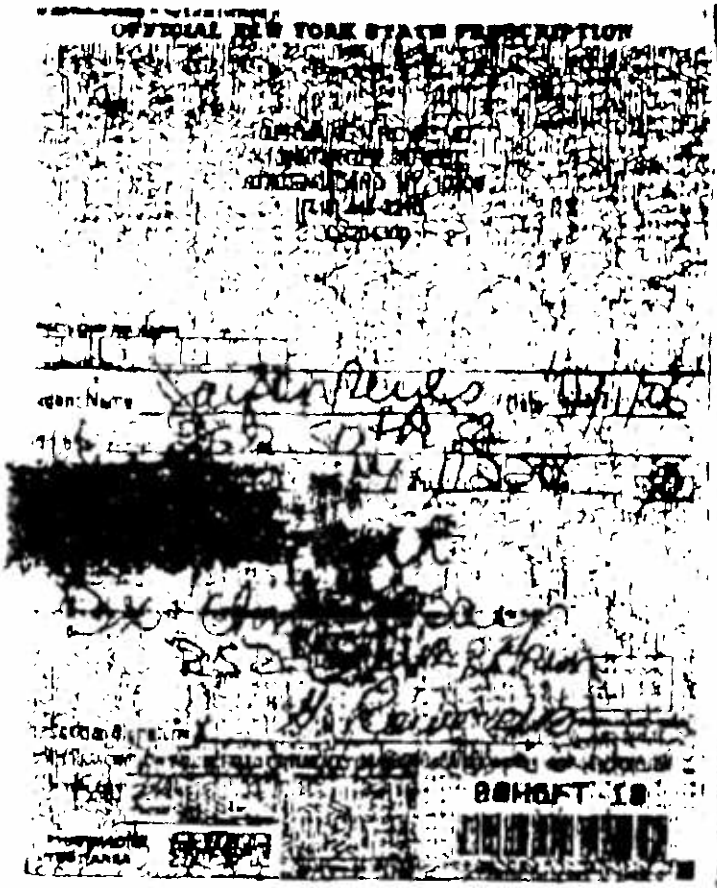
COMPANY:

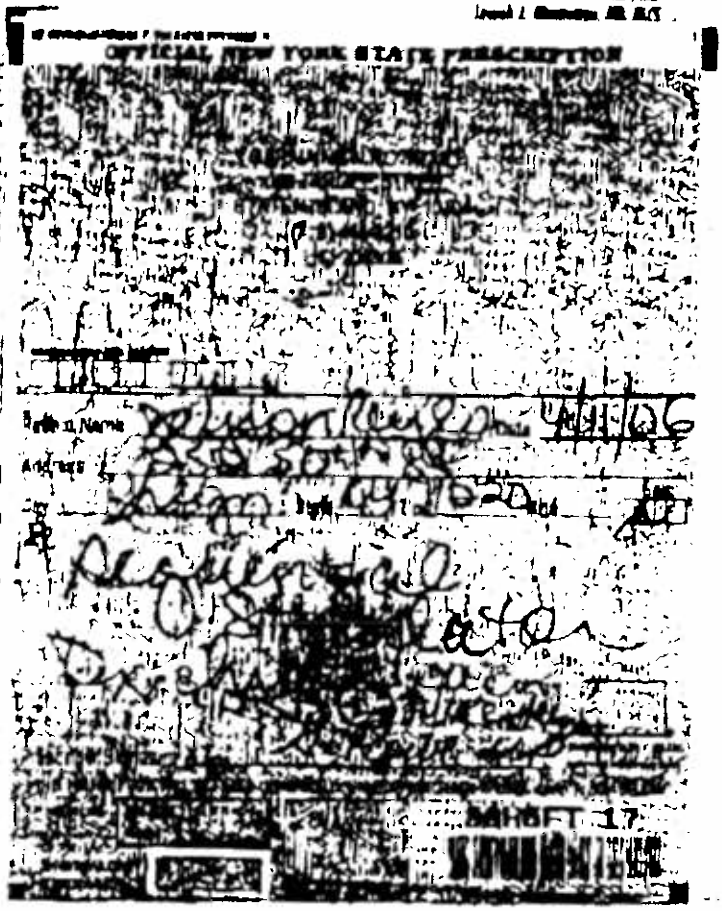
DEPT:

FAX: 398-8925

FAX: 718-447-7192
TEL. 718-448-8210 X

RE





9920 4th Avenue
Brooklyn, NY 11209

3311 Hylan Boulevard
Staten Island, NY 10306

56 Columbus Avenue
Staten Island, NY 10304

1460 Victory Boulevard
Staten Island, NY 10301

NYC 000123

02/13/06
18 11 13

RITE AID [redacted] AVE
[illegible] 23 [illegible] [redacted]
BROOKLYN NY [redacted] [illegible]
(718) 56[illegible] 5476

PAGE 1

CUSTOMER HISTORY REPORT
[illegible]

K[illegible]S, [illegible]
[illegible] ST
BROOKLYN NY 11220 [illegible]
(718) 439 [illegible]721

RX / CF	RF	DATE	NDC / PH UNIT	DESCRIPTION / CLAIM REF NBR	QTY DISP	DAYS SUPPLY	RETAIL PRICE	CUST PAID	DOCTOR	INSTRUCTION	STORE
2[illegible]		02/[illegible]/05	[illegible]1201	OXYCODONE W/APAP 5/325 / 226256060[illegible]126	75 00	25	$37 9[illegible]	$ 00	ROWE GERMAINE N	Take [illegible] tab et ever	04269
258329		02/[illegible]/05	63481068706 / HM2	LIDODERM 5% PATCH / 225[illegible]55507114	60 00	2[illegible]	$415 99	$ 00	ALCOCK NAOMI	[illegible] as directed 12	04269
258329	1	0[illegible]/23/05	63481068706 / HM2	LIDODERM 5% PATCH / 257001150023[illegible]	60 00	20	$415 99	$ 00	ALCOCK NAOMI	Use as directed [illegible]	04269
26[illegible]		0[illegible]/31/04	00406[illegible]1201 / TB1	OXYCODONE W/APAP 5/325 / [illegible]59[illegible]7650631[illegible]	75 00	[illegible]	$[illegible] 98	$ 00	ALCOCK NAOMI	Take [illegible] tab et ever	04269
[illegible]		06/07/05	[illegible]789121[illegible] / TB1	FENTANYL 25 MCG/H PATC / [illegible]0306950603[illegible]	[illegible] 00	[illegible]	$1[illegible] [illegible]	$ [illegible]	ALCOCK NAOMI	Apply 1 patch [illegible]	04269
[illegible]318		08/[illegible]/05	63481068706 / TB1	LIDODERM 5% PATCH / 2862[illegible]145[illegible]68	60 [illegible]	20	$437 99	$ 00	ALCOCK NAOMI	[illegible] UP [illegible] 3 PATCH	04269
278319		06 29 05	00406[illegible]	OXYCODONE W/APAP 5/325 / 285[illegible]145503[illegible]	75 00	2[illegible]	$37 98	$ 00	ROWE MD GERMAINE	take 1 tablet [illegible]	04269
2783[illegible]		08/31/05	00[illegible]7[illegible]5460 / TB1	[illegible]OXYCODONE [illegible] 10 MG TAB / 285[illegible]4[illegible]4[illegible]0[illegible]312[illegible]	60 [illegible]	30	$85 39	$ 00	ROWE MD GERMAINE	take 1 tablet ever	04269
285447		11/07/05	00406051201 / TB1	OXYCODONE W/APAP 5/325 / 30684003[illegible]10[illegible]	75 [illegible]	[illegible]	$[illegible] 98	$ 00	ROWE MD GERMAINE	take 1 tablet ever	04269
2[illegible]445		11/[illegible]/05	0002[illegible]3730 / TB1	CYMBALTA 60 MG CAPSULE / 3068[illegible]05[illegible]1[illegible]18	30 00	[illegible]	$138 99	$ 00	ALCOCK NAOMI	[illegible] 1 caps [illegible]	04269
276318	[illegible]	[illegible]/07/05	63481066706 / TB1	LIDODERM 5% PATCH / 3066372[illegible]10748	60 00	20	$437 9[illegible]	$ 00	ALCOCK NAOMI	WEAR UP TO 3 PATCH	04269
285448		11/09/05	00591350201 / TB1	OXYCODONE HCL CR 20 MG / 3[illegible]640/55[illegible]094[illegible]	60 00	30	$17[illegible] 59	$ 00	ROWE MD GERMAINE	Take [illegible] tablet ever	04269
2783[illegible]	2	01/01/06	63481068706 / K[illegible]	LIDODERM 5% PATCH / 3216725[illegible]68	60.00	70	$437 99	$ 00	ALCOCK NAOMI	WEAR UP TO 3 PATCH	04269
291346		01/02/06	0059[illegible]360707 / TG[illegible]	OXYCODONE HCL CR 20 MG / 321688[illegible]01024[illegible]	60 00	30	$170 99	$ 00	ROWE MD GERMAINE	take 1 tablet by [illegible]	04269
[illegible]94458		01 30/06	00406112101 / TG[illegible]	METHYLIN 5 MG TABLET	60.00	30	$29.99	$29 99	ROWE MD GERMAINE	take 1 tablet @ AM	04269
294457		01/30/06	00591350201 / TG[illegible]	OXYCODONE HCL CR 20 MG / 1297564601[illegible]096	60 00	70	$168 99	$ 00	ROWE MD GERMAINE	take 1 tablet by [illegible]	04269
							$3 1[illegible] 80	$29 99			

* * * * * * * * * THIS REPORT CONTAINS PATIENT HEALTH INFORMATION WHICH IS LEGALLY PROTECTED UNDER HIPAA LEGISLATION * * * * * *
* * * * * * * * * * * THIS INFORMATION MUST BE USED AND STORED IN ACCORDANCE WITH RITE AID PRIVACY POLICIES * * * * * * * * * * * *